

Name \_\_\_\_\_ Date \_\_\_\_\_ Pt # \_\_\_\_\_

**LOWER EXTREMITY FUNCTIONAL INDEX**

We are interested in knowing if you are having any difficulty with the activities listed below because of your lower limb (leg) problem for which you are currently seeking treatment. Please provide an answer for each activity.

**Today, do you or would you have any difficulty at all with:** (Circle number on each line)

<b><u>Activities</u></b>	<b>Extremely Difficult</b>	<b>Very Difficult</b>	<b>Moderately Difficult</b>	<b>Somewhat Difficult</b>	<b>Not Difficult</b>
Any of your usual work, housework or school work	0	1	2	3	4
Your usual hobbies, recreational or sporting activities	0	1	2	3	4
Getting into or out of the bath	0	1	2	3	4
Walking between rooms	0	1	2	3	4
Putting on your shoes or socks	0	1	2	3	4
Squatting	0	1	2	3	4
Lifting an object, like a bag of groceries from the floor	0	1	2	3	4
Performing light activities around your home	0	1	2	3	4
Getting into or out of a car	0	1	2	3	4
Walking 2 blocks	0	1	2	3	4
Walking a mile	0	1	2	3	4
Going up or down 10 stairs (about 1 flight of stairs)	0	1	2	3	4
Standing for 1 hour	0	1	2	3	4
Sitting for 1 hour	0	1	2	3	4
Running on even surfaces (pavement, track, gym)	0	1	2	3	4
Running on uneven surfaces (grass, trails, beach)	0	1	2	3	4
Making sharp turns while running fast	0	1	2	3	4
Hopping	0	1	2	3	4
Rolling over in bed	0	1	2	3	4
<b>Column Totals:</b>					

Score: \_\_\_\_\_/80